



*Please present ALL Insurance cards and Drivers License at time of visit
COMPLETE ALL Fields as best as possible

Patient Information

Name: (First) _____ (MI) _____ (Last) _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: Single Married Divorced Widow

Mailing Address: _____

City: _____ State: _____ Zip: _____ Social Security#: _____

Home Phone: _____ Cell: _____ Email address: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer Address: _____

Pharmacy Name: _____ Town: _____ Phone#: _____

Primary Care Physician: _____ Town: _____ Phone#: _____

Referred by: Friend/Family Physical therapist/Chiropractor _____ Attorney _____ Other

Referring Physician: _____ Town: _____ Phone#: _____

Emergency Contact Name: _____ Relationship: _____ Phone#: _____

Primary Insurance Plan: _____ ID# _____

Address: _____

Primary Insurance Plan Holder's Name: _____ DOB: _____ Relationship to patient: _____

Mailing address of Plan Holder if different from patient: _____

Home Phone of Plan Holder: _____ Cell phone of Plan holder: _____

Secondary Insurance Plan: _____ ID# _____

Address: _____

Secondary Insurance Plan Holder's Name: _____ DOB: _____ Relationship to patient: _____

Patient Release: **MUST BE SIGNED BY PATIENT** : I understand that Sun Orthopaedic and Spine Care, LLC will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Sun Orthopaedic and Spine Care, LLC will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize Sun Orthopaedic and Spine Care, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: _____ Date: _____

CHIEF COMPLAINT

Reason for visit: CERVICAL/NECK/ARM LUMBAR/BACK/LEG SCOLIOSIS SHOULDER KNEE OTHER_____

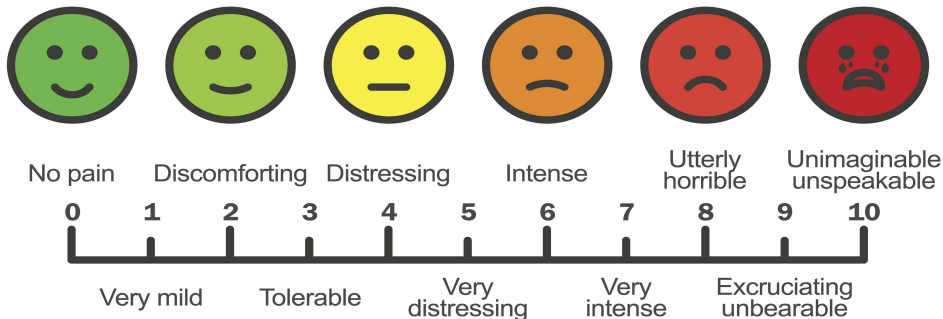
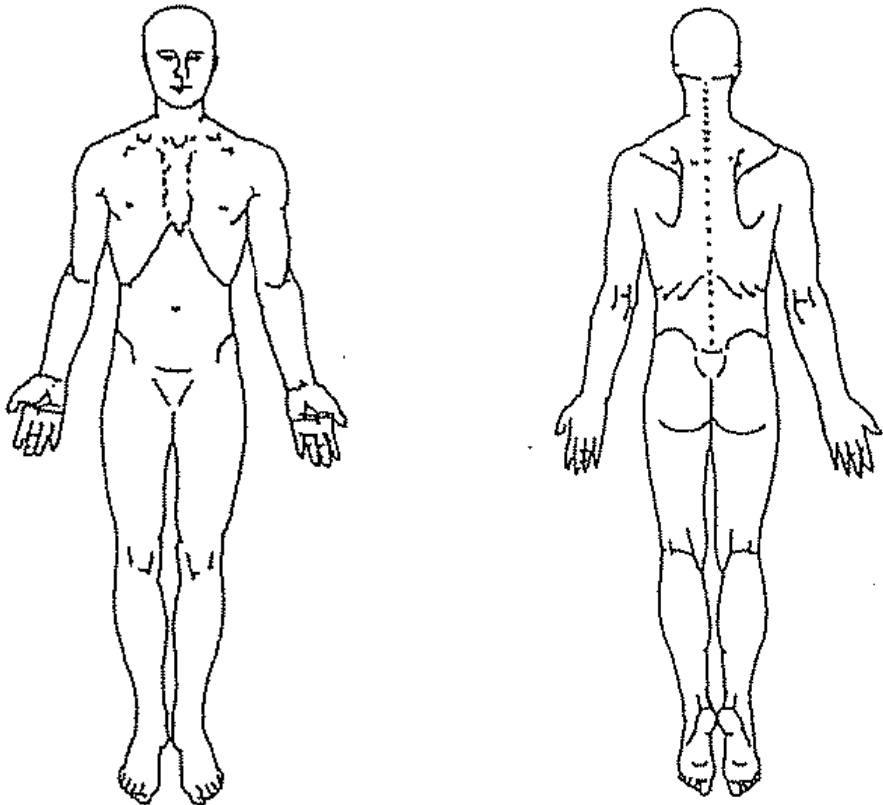
When did your condition start? (M/D/Y) ____ / ____ / ____

Please describe the reason(s) for your visit today: _____

Which side RIGHT LEFT BOTH **What is your dominant side:** RIGHT LEFT AMBIDEXROUS

Where are you experiencing pain?

- Please indicate **P** for pain, **N** for Numbness, **T** for Tingling in each area. Shade area as needed to show full area of pain
- If multiple locations please indicate where pain is most severe.



If you have had other Orthopedic / Spine injuries or surgeries, please describe:

Orthopedic / Spine injury: _____

Orthopedic / Spine surgery: _____

Describe the quality of the pain (check all that apply): DULL ACHY SHARP BURNING TINGLING

Is the pain constant or intermittent? CONSTANT INTERMITTENT

Associated symptoms (check all that apply) PAIN AT NIGHT STIFFNESS SWELLING

INSTABILITY WEAKNESS NECK/BACK PAIN RADIATING PAIN NUMBNESS/TINGLING

What makes it better? _____ **What makes it worse?** _____

Have you had prior studies?

X-RAY Date: ____/____/____ Facility: _____ Body part: _____

MRI Date: ____/____/____ Facility: _____ Body part: _____

CT SCAN Date: ____/____/____ Facility: _____ Body part: _____

EMG Date: ____/____/____ Facility: _____ Body part: _____

CURRENT MEDICATIONS (list all medications, vitamins, supplements)

<i>Name</i>	<i>Dose/Frequency</i>	<i>Name</i>	<i>Dose/Frequency</i>
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

KNOWN ALLERGIES (list any allergies and reaction): _____ **No Known Drug Allergy**

Are you allergic to... Iodine: Yes No Latex: Yes No Metal, jewelry, or nickel: Yes No

Are you currently on any blood thinners? No Yes If yes, which one: _____

Have you been taking opioids for 6+ months ? No Yes

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

Type of operation / reason for hospitalization

1. _____
2. _____
3. _____

Have you ever had a problem with anesthesia and/or surgery ? Yes No Problem: _____

Have you ever had a MRSA infection anywhere ? Yes No

Do you have any of the following medical devices (check any that apply) ?

Pain pump Neurostimulator/Spinal cord stimulator Pacemaker/Defibrillator Shunt for hydrocephalus

MEDICAL HISTORY (CHECK any past or current medical conditions below)

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Infection	<input type="checkbox"/> Pulmonary embolus
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Reflux
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Low acting thyroid	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Heart failure (CHF)	<input type="checkbox"/> Open wounds / Ulcers	<input type="checkbox"/> Seizures
<input type="checkbox"/> Blood clots (DVT)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Coronary heart disease	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Peripheral vascular disease	Other: _____
<input type="checkbox"/> Depression	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pneumonia	_____

FAMILY HISTORY (CHECK if any of your family have a history of any of the following)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Abnormal bleeding
<input type="checkbox"/> Heart disease (Heart attack)	<input type="checkbox"/> Rheumatoid arthritis (Inflammatory arthritis)
<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Anesthesia complications

SOCIAL HISTORY

Do you smoke tobacco? No Yes Past # packs per day _____ # of years _____

Do you use any other nicotine product (patch, vape, chew...)? No Yes Past

Do you drink alcohol? No Yes How many drinks per week?__ **History of substance abuse?** No Yes

List any recreational activities / sports you are involved in: _____

With whom do you live _____

Conservative Treatment prior to Office Visit today			
	Successful (Yes / No)	Did you experience temporary relief?	Comments (Last Visit)
Bed Rest			
Collar / Brace			
Analgesics / NSAIDs			
Physical Therapy			
Chiropractic Therapy Name of Chiropractor: _____			
Pain Management Name of Dr. _____			
Injections (Epidural / facet)			

REVIEW of SYSTEMS (Have you had any of the following in the past year?)

General	Weight loss or gain	Fatigue	Fever or chills	Weakness	Trouble sleeping	Change in appetite
Skin	Rashes	Lumps	Itching	Dryness	Color changes	Hair and nail changes
Head/Neck	Head injury	Headache	Neck lumps	Neck pain	Neck stiffness	Swollen glands
Ears	Decreased hearing	Ringing in ears (tinnitus)	Earache	Drainage		
Eyes	Glaucoma	Cataracts	Flashing lights	Specks / Floaters		
Nose	Stuffiness	Discharge	Itching	Hay fever	Nosebleeds	Sinus pain
Throat	Sore throat	Hoarseness	Mouth sores	Dentures	Sore tongue	Dry mouth
Cardio-vascular	Chest pain	Leg edema (swelling)	Palpitations	Loss of consciousness		
Gastro-Intestinal	Abdominal pain	Nausea / Vomiting	Diarrhea / Constipation	Bright red blood per rectum	Dark, black tarry stool	
Endocrine	Diabetes	Hyperthyroid	Hypothyroid	Sweating		
Respiratory	Cough (dry or wet, productive)	Sputum (color and amount)_____	Coughing up blood	Shortness of breath	Wheezing	Painful breathing
Neuro	Numbness / Tingling	Bowel / Bladder Incontinence	Seizures	Groin Numbness	Tremors	
Musculoskeletal	Hip pain	Knee pain	Shoulder pain	Back pain	Joint pain	

Patient Name _____ **Patient Signature** _____ **Date** _____

Reviewed by _____ **Date** _____